VETERANS WELLNESS RETREAT APPLICATION

PERSONAL INFORMATION (All personal information is confidential and treated accordingly.)

Service Member/Veteran Name* _____ DOB* _____

Last 4 digits of SSAN _____ Ethnicity _____ Tribal Affiliation _____

Name of Spouse/Partner* _____ DOB* _____

Last 4 digits of SSAN_____ Ethnicity _____ Tribal Affiliation _____

Relationship to Veteran if not spouse* _____

What first name would you like on your nametag? Veteran _____ Partner _____

Veteran Home Address* _____

City* _____ State* _____ Zip Code* _____

Number of Children _____ Ages/Gender _____

Home Phone* _____ Vet Cell Phone _____ Partner Cell Phone _____

Email _____

SERVICE INFORMATION

Branch of Service* _____ Service Years* _____ Discharge Date* _____

Combat Zone(s) _____ Deployment Dates _____

Name of MOS/AFSC _____

Awards/Decorations_____

Current Status:* ☐Active Duty ☐Military Retired ☐Veteran ☐Other: _____

Is your Spouse/Partner a military veteran?* Yes ____ No ____

If so, please provide the following:*

Branch of Service _____ Service Years _____ Discharge Date _____

Combat Zone(s) _____ Deployment Dates _____

Name of MOS/AFSC _____

Awards/Decorations _____

Current Status: ☐Active Duty ☐Military Retired ☐Veteran ☐Other: _____

*** Required information.**

POST TRAUMATIC STRESS (PTS) INFORMATION

The Veteran must have been diagnosed with PTS to attend a retreat.

Veterans PTS was diagnosed: Date/Year* _____ ☐ VA What VA Facility?* _____

If not VA, what Clinic or Professional Health Care Provider?* _____

Current/Past Counseling:* _____

_____

Has your Spouse/Partner been diagnosed with PTS? Yes _____ No_____ If so, please answer the following questions and complete the PTS questionnaire at the end of the application:

PTS was diagnosed: Date/Year_____ ☐ VA What VA Facility? _____

If not VA, what Clinic or Professional Health Care Provider? _____

Current/Past Counseling: _____

VETERAN PTS SYMPTOM QUESTIONNAIRE

Veteran Participant's Name* _____ Date* _____

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answers on problems

that started or got worse after the event. **The event you experienced was** _____

_____

(Name event) in _____ (month/year when event occurred). Indicate how much were you bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean twenty days out of the past 30; Moderately might mean ten to fourteen days; and A Little Bit might mean any number of days less than ten days out of the last 30. If you were not bothered by the indicated problem at all during the last 30 days, select Not at All.

*** Required information.**

VETERAN PTS SYMPTOM QUESTIONNAIRE (Continued)*

Participant ID # _____ (Center Use Only)

	Response	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4	Feeling very upset when something reminded you of the stressful experience?					
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or					
8	Trouble remembering important parts of the stressful experience (for some reason besides a head injury or alcohol					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10	Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Feeling irritable or angry or acting aggressively?					
16	Taking too many risks or doing things that could cause you					
17	Being "super alert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					
20	Trouble falling or staying asleep?					

*** Required information.**

PARTNER / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE

Partner/Support Person Name* _____ Date* _____

The purpose in having you to join your veteran is not only for you to help provide support and healing to them, but also to provide a healing opportunity for you. Our focus throughout the retreat will be to meet the needs of both you and your partner equally.

To help us do this, we would like to understand the degree to which you might be experiencing symptoms of stress in your life whether the symptoms result from your own history of trauma, the normal stresses of life, or from your relationship with someone who has PTS. Please answer the two questions below, and complete the attached PTS questionnaire.

Where the questionnaire uses the term "the stressful experience", you may answer according to a specific experience you have had or to the overall stress you experience in your life.

Before you complete the questionnaire, please answer the following questions:

1. On average, to what degree do you experience normal stress/distress? 0-10 (0 = none; 10 = extreme) _____
2. Have you had an experience(s) where you felt your ethics (your sense of right and wrong) was strongly violated, resulting in a significant sense of self-blame, shame, confusion, anger/rage or depression? _____

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answers on problems that started or got worse after the event. **The event you experienced was** _____

_____

(Name event) in _____ (month/year when event occurred). Indicate how much were you bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean twenty days out of the past 30; Moderately might mean ten to fourteen days; and A Little Bit might mean any number of days less than ten days out of the last 30. If you were not bothered by the indicated problem at all during the last 30 days, select Not at All.

*** Required information.**

PARTNER / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE (Continued)*

Participant ID # _____ (Center Use Only)

	Response	Not At All	A Little Bit	Moderately	Quite A Bit	Extremely
1	Repeated, disturbing, and unwanted memories of the stressful experience?					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4	Feeling very upset when something reminded you of the stressful experience?					
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities,					
8	Trouble remembering important parts of the stressful experience (for some reason besides a head injury or					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10	Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Feeling irritable or angry or acting aggressively?					
16	Taking too many risks or doing things that could cause you					
17	Being "super alert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					
20	Trouble falling or staying asleep?					

*** Required information.**

MEDICAL INFORMATION

VETERAN:

Service connected disability: **%** _____ Condition/Basis _____

Prescription Medications: _____

_____

NOTE: The nearest pharmacy is 35 miles away so bring at least an 8-day supply of prescription medications.

VETERAN Physical Conditions that require assistance/unique accommodations: ☐ Motorized Wheelchair

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other: _____

Medical Conditions: ☐ Diabetic ☐ Oxygen ☐ Nebulizer ☐ CPAC or other similar equipment. Other Medical Conditions: _____

Sensitivities or Allergies: ☐ Smoke ☐ Other: _____

Dietary: ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Other:
_____

Service Animal: Purpose _____ Certified? Yes ☐ No ☐ Breed:
_____

PARTNER:

Service connected disability (if also Veteran): **%** _____ Condition/Basis _____

Prescription Medications: _____

_____

Physical Conditions that require assistance/unique accommodations: ☐ Motorized Wheelchair

☐ Wheelchair ☐ Walker ☐ Cane ☐ Other: _____

Medical Conditions: ☐ Diabetic ☐ Oxygen ☐ Nebulizer ☐ CPAC or similar equipment

Other: _____

Sensitivities or Allergies: ☐ Smoke ☐ Other: _____

Dietary: ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Other: _____

Service Animal: Purpose _____ Breed _____

*** Required information.**

RETREAT INFORMATION

Participants should arrive at the retreat location between the hours of 12:00 PM and 3:00 PM. Travel will be paid by the participant. The Retreat does not cover any travel expenses. Lodging and meals will be provided at no cost to the participants. Due to the nature of these retreats, children are not allowed to attend.
Comfortable, casual attire such as jeans, shorts, tennis shoes, bathing suits, hats and sunscreen are recommended. Closed toed shoes are necessary for equine therapy. Some activities will require exercise or loose clothing. Cool evening temperatures are expected and sweaters and light jackets are appropriate. Participants should bring pants or ankle length skirts for Native American ceremonies. We also have an evening dinner with dancing, please bring appropriate clothing.

We conduct Equine Therapy on the first full day of the retreat followed by a very mellow horseback or wagon ride. We want to ensure we have the right number of saddled horses. Please indicate if you think you might do the horseback ride of if you expect to participate in the wagon ride. If you are unsure, just mark "Horse Back Ride"

Veteran Horse Back Ride? Yes ☐ No ☐ If "Yes," Height: _____feet _____ inches. Weight: _____ lbs.

Partner Horse Back Ride? Yes ☐ No ☐ If "Yes," Height: _____feet _____ inches. Weight: _____ lbs.

IF YOU A SINGLE VETERAN WHO HAS NO PARTNER, but would be willing to partner with another vet who has completed the retreat and can mentor you during and after your retreat, please indicate below.

☐ Yes, I would like a another Veteran to be your PTS support person during and after the retreat.

☐ No, I do not want a Veteran support person during and after the retreat. I will continue to seek a partner before my retreat.

For questions relative to the Retreat Application process, please call (575) 377-5236.

Once your application has been received and processed, you will be notified and placed in one of our first available scheduled retreats. See Center webpage (www.veteranswellnessandhealing.org) for retreat schedule. If circumstances require a particular retreat start date, please indicate below. **Availability is limited.**

1st Choice _____ 2nd Choice: _____

Mail the entire completed Retreat Application to:
National Veterans Wellness and Healing Center
PO Box 805
Angel Fire, New Mexico 87710

Email scanned applications to application@veteranswellnessandhealing.org.

We have read the entire application and believe all of the answers given on the Retreat Application are true and correct.
We have also read the Center's health information privacy practices.

_____ _____
Signature of Service Member/Veteran* Date *

_____ _____
Signature of Spouse/Partner* Date *

How did you hear about the National Veterans Wellness and Healing Center? _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARFULLY

If you have any question about this notice, please contact the National Veterans Wellness and Healing Center's ("Center") Privacy Officer.

This Notice Describes Our Practice and those of:
Any Center contracted provider or staff that provide services to you or any volunteer the Center allows to help you during your retreat. All of these people follow the terms of this notice. They may also share protected health information with each other for services provided or other retreat-related operations described in this notice.

Our Pledge Regarding Health Information:
We understand that health information about you and your health is personal. Your health information is contained in a record that is the physical property of the Center. We are committed to protecting health information about you. This notice will tell you about the ways in which we may use and disclose health information. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

The Center is required by law to:
Make sure that medical information that identifies you is private. Give you this notice of our legal duties and privacy practices with respect to health information about you. Accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations. Follow the terms of the notice that is currently in effect.

How the Center may use or disclose your health information:
For Retreat Services. The Center may use your health information to provide you with services. For example, a provider, such as a counselor, may record information in your record that is necessary for your successful retreat experience. This information is necessary for the provider to determine what service you should receive. Providers may also record actions taken by them or other retreat providers in the course of the retreat and note how you respond to the actions. Your information may also be used for aftercare following the retreat.
For Retreat Operations. The Center may use and disclose health information for operational purposes. For example, your health information may be disclosed to members of the retreat staff or Center volunteers to assign counselors, evaluate the performance of our providers, assess the quality of service and outcomes, learn how to improve our facilities and services, and determine how to continually improve the quality and effectiveness of the retreats.
For Post Traumatic Stress related activities. The Center may use your information to contact you to provide reminders and information of your scheduled retreat. The Center may also contact you about services, activities, or health-related benefits that may be of interest to you.
Others involved in your care. The Center may release relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or aftercare.

Outreach to other Veteran Families. The Center will not release any health information for the purpose of informing and educating others in the military and veteran community about Post Traumatic Stress and the Center's programs without you written authorization.

Fundraising: The Center will not release any health information for the purpose of fundraising without you written authorization.
Required by law. The Center may use and disclose information about you as required by law. For example, the Center may disclose information to report suspected abuse or neglect, or similar injuries or events.
Law enforcement purpose. Subject to certain restrictions we may disclose information required by law officials.
Judicial and administrative proceedings. We may disclose information in response to an appropriate subpoena, discovery request or court order.
Health oversight activities. We may disclose your health information to a health oversight agency for activities authorized by law.
Research. We may use your health information for research purposes after a receipt of authorization from you.
Health and safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
Other uses and disclosures. Other uses and disclosures will be made only with your written authorization. You may revoke an authorization except to the extent that the Center has taken action reliant on it.

Your health information rights:
You have the right to:

- Obtain a paper copy of this notice of information practice upon request.
- Inspect and obtain a copy of our health information practices upon request.
- Request an amendment to your health information that is maintained by the Center.
- Request confidential communications of your health information by alternative means or at alternative locations.
- Receive an accounting of disclosures made of your health information. Request a restriction on certain uses and disclosures of your information. The Center is not required to agree to a requested restriction.

Changes to this notice: The Center reserves the right to change the terms of this notice. The Center can make the new terms effective for all protected health information kept by the Center. You may also get a current copy by contacting the Center Privacy Officer.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Center Privacy Officer or with the Secretary for the Department of Health and Human Services. To file a complaint with the Center, submit your written complaint to our Privacy Officer. You will not be penalized for filling and complaint.

Contact information for questions or to file a complaint: If you have any question about this notice, want to exercise one of our rights that are described in the notice, or want to file a complaint, please contact the Center Privacy Officer at the National Veterans Wellness and Healing Center, PO Box 805, Angel Fire, NM 87710.